SMILES INC

Special Methods In Learning Equine Skills

EQUINE RECREATION REGISTRATION AND RELEASE FORM

DATE: _____ RIDER'S NAME: _____ DOB: _____
STREET: _____CITY:_____ ZIP: _____
COUNTY: _____HOME PHONE: (_____) _____Gender____
PARENT OR GUARDIAN _____School/Group_____
PRIMARY DISABILITY: _____OTHER DISABILITIES_____
ADAPTATIONS: _____HAS STUDENT EVER RIDDEN A HORSE: Yes/ No
EMAIL_____ Ethnic group: _____

LIABILITY RELEASE

_____ (Rider's name) would like to participate in the SMILES program. I acknowledge the risks and potential for risks of horseback riding. However, I feel the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against SMILES, its Board of Directors, Instructors, Therapist's, Aids, Volunteers and/or Employees for any and all injuries and /or losses I/my son/my daughter/my ward may sustain while participating in SMILES program.

Date: _____ Signature: _____
Client, Parent or Guardian

PHOTO RELEASE

I hereby consent to and authorize the use and reproduction by SMILES of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities or for any other use for the benefit of the program (Signature of this release is optional.)

Date: _____ Signature: _____
Client, Parent or Guardian

RIDER'S AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize SMILES to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Physician's Name: _____ Preferred Medical Facility_____

Health Insurance Co. _____ Policy # _____

EMERGENCY NUMBERS

IN CASE OF AN EMERGENCY or in the event that I cannot be reached: CONTACT:
_____PHONE_____

OR CONTACT: _____PHONE_____

(PLEASE SEE OTHER SIDE)

CONSENT PLAN

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Date: _____ Print Name: _____ Phone: _____

Address: _____

Consent Signature_____
Client, Parent or Guardian

SMILES strives to provide the safest atmosphere possible, for this reason paperwork must be filled out completely. Any rider 150 pounds or more must be able to remain centered and balanced without requiring side-walkers. To ensure the horse can safely carry their rider, SMILES cannot accommodate a rider over 300 pounds.

PHYSICIANS RELEASE

DIAGNOSIS_____DATE OF ONSET_____

NOTE: IF DOWN SYDROME, EVALUATE FOR ATLANTOAXIAL INSTABILITY.
DATE OF X-RAY_____ POSITIVE_____ NEGATIVE_____

Present medical and functional status (i.e. visual/audio limitations, seizures, balance, etc _____)

_____

_____**Allergies**_____

Height_____Weight_____

Mobility: Independent ambulation Y N Assisted ambulation Y N Wheelchair Y N

In my opinion, this patient can receive therapeutic horseback riding instruction under appropriate supervision.

Physician Signature_____

OR

Due to contraindications or if SMILES determines this activity would be unsafe for this rider, this patient can participate in un-mounted activities.

Physician signature_____**Date**_____

SMILES
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